AGENDA ITEM 5

RHONDDA CYNON TAF COUNTY BOROUGH COUNCIL

CORPORATE PARENTING BOARD

7TH DECEMBER 2015

SAFEGUARDING ACTION PLAN REPORT

REPORT OF THE GROUP DIRECTOR, COMMUNITY AND CHILDREN'S SERVICES

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1. PURPOSE OF REPORT

To inform the Corporate Parenting Board of the completion of the current Children's Services Safeguarding Action Plan (SAP).

2. RECOMMENDATIONS

2.1 That the Corporate Parenting Board notes the report.

3. BACKGROUND

As members will be aware from previous reports; following the publication of the Serious Case Review regarding the death of baby Peter in Haringey at the end of 2008, CSSIW required a series of actions from all Local Authorities (LAs) and Local Safeguarding Children Boards (LSCBs), to be satisfied about the effectiveness of safeguarding arrangements in Wales.

Children's Services were therefore required to carry out an audit of the Council's compliance at that time with the recommendations from the Victoria Climbie inquiry report, published in 2003.

Subsequently Care and Social Services Inspectorate Wales (CSSIW) inspectors visited RCT in April 2009 to conduct an inspection to verify the reviews of effectiveness undertaken by both Children's Services and the then RCT LSCB. The final inspection reports were received at the end of October 2009.

Furthermore RCT LSCB was subject of a multi inspectorate inspection during February 2011 the resulting report was published in October 2011 and was subject of a report to CPB in November 2011.

In addition during the latter part of 2011, RCT LSCB published an executive summary of the Serious Case Review (SCR) for Child MM and a combined executive summary for the SCRs for Child K, Child N and Child R.

Subsequently Cwm Taf Safeguarding Children Board (RCT LSCB successor body) was involved in piloting Child Practice Reviews (CPR) the arrangements which replaced Serious Case Reviews; and published individual reports in January and December 2013 as well as June 2014

A looked after children safeguarding report was produced and reported to CPB in May 2013.

4. CHILDREN'S SERVICES SAFEGUARDING ACTION PLAN (SAP)

Members will appreciate that the actions that are required to ensure effective safeguarding, stem not only from external inspection processes but also from internal reviews and audits, from Child Practice Reviews, from national reports, from national policy shifts and from collaborative developments with partners. Actively progressing, integrating and monitoring the actions required is therefore both a highly complex undertaking and subject to change over time.

The Head of Safeguarding and Standards therefore, developed a Safeguarding Action Plan (SAP) as a management tool to enable managers across the service to sustain the process of improvement and review progress regularly.

This SAP incorporated all of the relevant actions stemming from the CSSIW Inspection; those remaining that were identified as part of the audit of compliance with the requirements of the Victoria Climbie Report 2003; and those resulting from Serious Case Reviews/Child Practice Review reports and the looked after children safeguarding report.

Progress against the SAP has been reported to Corporate Parenting Board annually.

5. CURRENT POSITION

The established SAP review group which had representation from across Children's Services continued to meet through early 2015 to monitor progress. The SAP was also considered by the Children's Services Management Team. In addition Cwm Taf Safeguarding Children Board (CTSCB) also monitors implementation of CPR action plans including any Childrens Services actions. Childrens Services individual Serious Case Review action plans are all now completed.

The group has now concluded that the actions contained within the SAP have either been completed, subsumed within the remodelling work within Childrens Services or being taken forward by CTSCB including its MASH arrangements. Consequently this will be the final SAP report to CPB.

Listed below are the key achievements SAP for 2015 and the actions that will now be taken forward in a different way.-

- As CPB will be aware MASH has been operational for Childrens Services since May 2015 it risk assesses all safeguarding contacts for children and adults on a multi agency basis and decides upon the required response. Its purpose is to make better informed decisions in a more timely way and therefore improve outcomes for vulnerable children and adults. MASH utilises a specifically designed electronic system MHUB. EDT have been located within MASH since January 2105. Oversight of the MASH rests with both CTSCB and CTSAB.YOS data base accessibility to MASH an action within the SAP will be taken forward by the Safeguarding Boards MASH steering group arrangements.

- The LAC Safeguarding report actions have now been completed.
  1. Long term visiting guidance has now been produced and agreed across Cwm Taf. This relates to children placed in long term education or health settings. These children are not looked after but can be very vulnerable given the complex nature of their needs and the fact they are placed away from home for long periods. The guidance sets out the frequency and requirements of visits and also ensures an IRO will now be made available for each child although this will need to be with parental agreement

  2. In addition specific guidance has been produced regarding the expectations of staff when children are placed with 'non-framework' providers of external placements, this includes accreditation and placement visiting requirements. Such placements are those outside of the 4 C's arrangements and only used when all other avenues have proved unsuccessful. Children and young people and therefore likely to have significant additional needs.

  3. A checklist has been produced and circulated for IROs and Social workers visiting placements.

  4. Arrangements for 'spot check' visiting external residential providers are in place.

  5. Arrangements are in place to contribute to the 4C's complaint process.

6. Lastly a review has been conducted of the panel arrangements, both statutory and operational that makes decisions about looking after children. The process has been considerably streamlined, and accountability clarified. This became operational in January 2015 LAC Quality assurance panel being established as a part of the process.

- Childrens Services contributed significantly to the CTSCB work in developing risk assessment and risk management guidance in relation to young people at risk for example through going missing, being sexually exploited, misusing substances or displaying sexually harmful behaviour. .

  The guidance was completed, signed off by the Safeguarding Board and implemented including training being provided. However CTSCB has identified problems with its implementation and is currently in the process of consulting with practitioners as to the reasons for this as well as reviewing the guidance itself and ensuring additional training is provided Childrens Services are key to the work.

  In addition CTSCB has to consider the implications for this protocol of the CSE reports published nationally. The Board has its own action plan and has been contributing to the work of WG in devising a national action plan and the CCW, PCC groups. CTSCB is best placed to lead this work

- CTSCB has the responsibility for considering safeguarding e-learning opportunities as part of its ongoing Training and Communications Sub group work.

- The Interconnect IT project became IT services lead but has now been overtaken by national plans to provide a joint Health and Social care electronic system. IT are leading the work and including both adults and Childrens Services as appropriate.

- Wales Audit Office Safeguarding report recommendations are whole LA rather than Children Services focussed and are being taken forward by Corporate Services Children Services contributing as required through the Head of Safeguarding.